THE NEW INDIA ASSURANCE CO. LTD.

REGISTERED & HEAD OFFICE: 87, MAHATMA GANDHI ROAD, MUMBAI - 400 001.

NEW INDIA PREMIER MEDICLAIM PROSPECTUS

We welcome You as Our Customer. This document explains how the NEW INDIA PREMIER POLICY could provide value to You. In the document the word 'You', 'Your' means all the members covered under the Policy. 'We', 'Our', 'Us' means The New India Assurance Co. Ltd.

New India Premier is a Policy designed to cover Hospitalisation expenses of the Persons You wish to cover under this Policy.

1. WHO CAN TAKE THIS POLICY?

All the persons proposed for this Insurance should be between the age of 18 years and 65 years. Children between the age of 3 months and 18 years are covered provided one or both parents are covered concurrently. Children between 18 years to 25 years can be covered provided they are financially dependent on the parents and one or both parents are covered simultaneously. On attaining the age of 18 years or ceasing to be financially dependent on the parents, they can, on renewal take a separate Policy. In such an event the benefits on Continuous Coverage can be ported to the new Policy. The upper age limit will not apply to a mentally challenged children and an unmarried dependent daughter(s). The persons beyond 65 years can continue their Insurance provided they are Insured under the Policy with us without any break.

Midterm inclusion is allowed for newly married spouse by charging pro-rata Premium for the remaining period of the Policy. A New Born Baby, born to an Insured mother, will be covered from date of birth till the expiry of the Policy, without any additional Premium. No coverage for the New Born Baby would be available during subsequent Renewals unless the child is declared for Insurance and covered as an Insured Person.

2. CAN I COVER MY FAMILY MEMBERS IN ONE POLICY?

Yes. You and Your entire family can be covered under this Policy. The members of the family who could be covered under the Policy are:

a) Proposer

b) Spouse

c) Dependent Children

d) Dependent Parents.

Minimum one and maximum six members can be covered in this Policy.

3. WHAT DOES THE POLICY COVER?

This Policy is designed to give You and Your family, protection against unforeseen Hospitalisation expenses.

4. WHAT ARE THE PLANS OFFERED IN THIS POLICY?

This Policy has two plans viz:

a) **Plan A:** offers Sum Insured of Rs. 15,00,000 and 25,00,000.

b) **Plan B:** offers Sum Insured of Rs. 50,00,000 and 100,00,000.

The Sum Insured chosen by You and accepted by Us represents Our maximum liability towards all payments admissible under the Policy in respect of all Insured Persons. Only payment under Critical Care Benefit will not reduce the Sum Insured. All other payments in respect of any admissible claim in respect of any Insured Person shall reduce the Sum Insured.

Please select for the right amount of Sum Insured based upon Your current and future needs.

5. WHAT IS ABHA NUMBER?

ABHA stands for **AYUSHMAN BHARAT HEALTH ACCOUNT (ABHA),** a number is a hassle-free method of accessing and sharing health records digitally. It enables interaction with participating healthcare providers, and allows to receive digital lab reports, prescription and diagnosis seamlessly from a verified healthcare professionals and health service providers

6. IS PRE-ACCEPTANCE MEDICAL CHECK-UP REQUIRED?

Pre-acceptance medical check-up is required for all the members entering after the age of 50 years. A person also needs to undergo this pre-acceptance medical check-up if he has an adverse medical history or if the health condition of the person/s to be Insured is such that the office in-charge feels that he / she be subjected to a medical examination.

The cost of this check-up will be borne by the proposer. But if the proposal is accepted, then 100% of the cost of this check-up will be reimbursed to the proposer.

Pre-acceptance medical check-up shall be conducted at designated centers authorized by Us.

Note: Adverse Medical History means a person:

a) who has undergone more than one Hospitalisation in previous two years,

b) who is suffering from Critical Illness, Recurring Illness or Chronic Illness.

c) who has BMI greater than or equal to 32.

d) who has any Psychiatric and Psychosomatic Disorder.

7. WHAT ARE THE EXPENSES COVERED UNDER THIS POLCY?

Policy covers following Hospitalisation Expenses:

1.	Room rent, Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses).
2.	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses.
3.	Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Blood, Oxygen, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.
4.	Cost of Pharmacy and Consumables, Cost of Implants and Medical Devices and Cost of Diagnostics.
5.	Pre-Hospitalisation Medical Expenses, upto sixty days.
6.	Post-Hospitalisation Medical Expenses, upto ninety days.

Note: Procedures/treatments usually done in OPD are not payable under the Policy even if converted as an in-patient in the Hospital for more than 24 hours or carried out in Day Care Centres (except specifically mentioned under OPD treatments clause).

SPECIFIC COVERAGES:

a) **Impairment of Persons' intellectual faculties** by usage of drugs, stimulants or depressants as prescribed by a medical practitioner is covered up to 5% of Sum Insured per policy period, subject to it arising during treatment of covered Illness.

b) **Artificial life maintenance,** including life support machine use, where such treatment will not result in recovery or restoration of the previous state of Health under any circumstances unless in a vegetative state as certified by the treating medical practitioner, is covered up to 10% of Sum Insured and for a maximum of 15 days per policy period following admission for a covered illness. (Explanation: Expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the policy contract).

c) **Puberty and Menopause related Disorders:** Treatment for any symptoms, Illness, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing is covered only as Inpatient procedure after 24 months of continuous coverage. This cover will have a sub-limit of up to 25% of Sum Insured.

d) **Age Related Macular Degeneration (ARMD)** is covered after 36 months of continuous coverage only for Intravitreal Injections and anti - VEGF medication. This cover will have a sub-limit of Rs. 1,00,000 per policy period.

e) **Behavioral and Neuro developmental Disorders:** Disorders of adult personality and Disorders of speech and language including stammering, dyslexia; are covered as Inpatient procedure after 24 months of continuous coverage. This cover will have a sub-limit of 25% of Sum Insured.

f) **Genetic diseases or disorders** are covered with a sub-limit of 25% of Sum Insured per policy period with 36 months waiting periods.

COVERAGE FOR MODERN TREATMENTS OR PROCEDURES: The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to the limit specified against each procedure during the policy period.

S.No.	Treatment or Procedure	Limit (Per Policy Period)
1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Upto Rs. 2 Lakh
2	Balloon Sinuplasty	Upto Rs. 2 Lakh
3	Deep Brain stimulation	Upto Rs. 5 Lakh
4	Oral chemotherapy	Upto Rs. 1 Lakh
5	Immunotherapy- Monoclonal Antibody to be given as injection	Upto Rs 2 Lakh
6	Intravitreal injections	Upto Rs. 75,000
7	Robotic surgeries	Upto Rs. 5 Lakh
8	Stereotactic radio surgeries	Upto Rs. 3 Lakh
9	Bronchial Thermoplasty	Upto Rs. 2.5 Lakh
10	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)	Upto Rs. 2.5 Lakh
11	IONM - (Intra Operative Neuro Monitoring)	Upto Rs. 50,000
12	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered	Upto Rs. 2.5 Lakh

8. HOW IS PREMIUM CHARGED AND TYPE OF POLICY?

This policy is issued on Individual as well as Floater basis.

If the Policy is issued on Individual basis (Separate Sum Insured for each member), Premium for all member will be calculated from Primary member premium Table.

If the Policy is issued on Floater basis (Single Sum Insured for each member), Premium for the eldest member will be calculated from Primary member premium Table and for rest of the members from Additional member Premium tables

9. WHAT IS HOSPITAL CASH BENEFIT?

This Policy provides for payment of Hospital Cash at the rate of Rs. 2,000 per day for Plan A and Rs. 4,000 per day for Plan B for Any One Illness. This benefit will be given in case of admissible claim only. The benefit is applicable only where Hospitalisation exceeds twenty-four consecutive hours.

The total payment for Any One Illness shall be made for maximum 10 days of Hospitalisation. Payment under this clause will reduce the Sum Insured.

Hospital Cash will be payable for completion of every 24 hours and not part thereof.

10. WHAT IS CRITICAL CARE BENEFIT?

If during the Period of Insurance any Insured Person is diagnosed for the first time to be suffering from any Critical Illness as listed below, we will pay Rs. 2,00,000 for Plan A and Rs. 5,00,000 for Plan B as additional benefit i.e., other than the admissible claim amount:

1. Cancer
2. First Heart attack of specified severity
3. Open chest CABG
4. Open Heart replacement or repair of Heart valves
5. Coma of specified severity
6. Kidney failure requiring regular dialysis
7. Stroke resulting in permanent symptoms
8. Major organ / bone marrow transplant
9. Permanent paralysis of limbs
10. Motor neurone disease with permanent symptoms
11. Multiple sclerosis with persisting symptoms

Any payment under this clause would be in addition to the Sum Insured and shall not deplete the Sum Insured. This benefit will be paid once in lifetime of any Insured Person. This benefit is not applicable for those Insured Persons for whom it is a Pre-existing Disease.

11. IN CASE OF AYURVEDIC TREATMENT, WILL THE ENTIRE AMOUNT BE PAID?

Expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines is covered up to 100% of Sum Insured, during each policy year as specified in the policy schedule.

12. WHAT ARE THE AMBULANCE CHARGES PAID UNDER THIS POLICY?

We will pay You the charges incurred towards Ambulance services including Air Ambulance for shifting any Insured Person to Hospital for admission or from one Hospital to another Hospital for better medical facilities maximum up to Rs. 1,00,000 for Any One Illness.

If an Insured Person after the discharge from the Hospital has to be shifted from Hospital to their place of residence in an Ambulance and is not able to travel otherwise, such expenses will also be reimbursed additionally up to Rs. 10,000 for Any One Illness, provided the requirement of an Ambulance is certified by the Medical Practitioner.

13. DOES THIS POLICY COVER ANY OPD TREATMENTS?

Yes. After every block of two continuous Claim Free Years, all the members covered in this Policy are entitled for OPD coverage of Rs. 5,000 for Plan A and Rs. 10,000 for Plan B cumulatively. The cover can be availed for:

1. Dental Treatment.
2. Health Check-up.
3. Consultation with a Medical Practitioner.
4. Drugs and Medicines as prescribed by a Medical Practitioner.
5. Investigations as prescribed by a Medical Practitioner.

The amount will not be carried forward to the next year.

A claim under OPD Treatment clause will also be treated as a claim for determining Claim Free Year.

14. WHAT IS MATERNITY AND CHILD CARE COVER?

Maternity shall be covered provided the Insured mother has Continuous Coverage of **thirty-six** months in New India Premier Mediclaim Policy. Our liability for expenses incurred towards Maternity, shall be restricted to Rs. 50,000 for Plan A and Rs. 1,00,000 for Plan B.

Special conditions applicable to Maternity and Child Care Benefit:

i. These benefits are admissible only if the expenses are incurred for the Insured Person in a Hospital as in patient.

ii. Claim under this clause shall not be admissible if, in respect of any Insured Person, two claims for Maternity Expenses have been paid by Us in the preceding / existing New India Premier Mediclaim policies.

For instance: An Insured person has availed Maternity benefit in 2017, and again in 2018, any subsequent claim for Maternity Benefit will not be available to her.

15. WHAT IS NEW BORN BABY COVER?

A New Born Baby is covered for any Illness or Injury from the date of birth till the expiry of this Policy, within the terms of this Policy and Plan opted without additional premium. Congenital External Anomaly of the New Born Baby is not covered under the Policy.

Any expenses incurred towards pre-term or pre-mature care or expenses incurred in connection with delivery of such New Born Baby are not covered under this clause.

No coverage for the New Born Baby would be available during subsequent renewals unless the child is declared for Insurance and covered as an Insured Person.

16. IS TREATMENT FOR INFERTILITY COVERED IN THIS POLICY?

Yes. We will cover expenses necessarily incurred for treatment of Infertility, including outpatient treatment, subject to a limit of Rs. 1,00,000 for Plan A and Rs. 2,00,000 for Plan

B. This limit shall be our maximum liability in respect of all Insured persons. If any claim is payable to any Insured Person under this clause in any particular Policy period, the benefit under this clause shall not be available for any subsequent renewals.

Any payment under this clause shall be paid after the Insured Person has Continuous Coverage of thirty-six months under New India Premier Mediclaim Policy.

17. IS HIV/AIDS COVERED IN THIS POLICY?

Yes. This Policy covers treatment for Sexually Transmitted Diseases, any condition directly or indirectly caused to or associated with Human T-Cell Lymphotropic Virus Type III (HTLB - III) or lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency Syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS. Any payment under this Clause shall only be made when the Insured Person was not afflicted with any of these conditions at the time of the proposal, and only when such condition is contracted subsequent to this Insurance, regardless of whether the Insured Person was aware or not of the same. The limit for the above cover will be up to:

Plan A: Rs. 2,00,000 and

Plan B: Rs. 5,00,000

The Insured needs to be admitted as in-patient for more than 24 hours.

Consultation for the above-mentioned conditions is available on OPD basis for Rs. 20,000 for Plan A and Rs. 50,000 for Plan B. The OPD limit will be part of the overall limit mentioned above.

Any payment under this clause shall be paid after the Insured Person has Continuous Coverage of thirty-six months under New India Premier Mediclaim Policy.

18. WHAT ARE THE MAXIMUM CHARGES PAID FOR TREATMENT OF CATARACT?

Expenses incurred towards cataract shall be paid as per the following limits:

Plan A: Actual charges up to a maximum of Rs. 75,000.

Plan B: Actual charges up to a maximum of Rs. 1,00,000.

19. ARE PSYCHIATRIC AND PSYCHOSOMATIC DISORDERS COEVRED?

All the Psychiatric and Psychosomatic disorders diagnosed after inception of this Policy will be covered up to 5% of Sum Insured. The Insured needs to be admitted as Inpatient. This treatment will not be covered as a Day-care procedure.

20. WHICH OBESITY TREATMENTS ARE COVERED IN THIS POLICY?

This cover will be available only for Plan B.

Treatment related to or for obesity is covered where BMI>35 and with co-morbidities mentioned below, up to Rs. 5,00,000

1. Respiratory: Obstructive sleep apnea, Pickwickian syndrome (obesity hypoventilation syndrome)
2. Cardiovascular: Coronary artery disease, left ventricular hypertrophy, coronary pulmonale, obesity-associated cardiomyopathy, accelerated atherosclerosis, and pulmonary hypertension of obesity

   Any payment under this clause shall be paid after the Insured has:

   a) Continuous Coverage of thirty-six months in New India Premier Mediclaim Policy.

   b) Such a treatment is payable only after prior clearance of Medical Practitioner authorized by the Company or TPA mentioned in the Schedule.

21. SECOND OPINION FOR MAJOR SURGERIES:

In case any Insured Person requires to undergo a Surgery as advised by a Medical Practitioner, then the expenses incurred towards consultation with another Medical Practitioner to seek advice on the surgery shall be payable up to Rs. 5,000 for Plan A and up to Rs. 8,000 for Plan B. Cashless facility for availing such second opinion will be provided by the TPA with enlisted Network Providers.

22. DIETICIAN COUNSELING:

This benefit is applicable only for Plan B.

Dietician counseling can be availed by any Insured Person. The cost of such dietician counseling in respect of all Insured Persons in a policy shall be restricted to a maximum of Rs. 5,000 subject to actuals.

23. CONCIERGE SERVICE

The services provided will be:

a. Facilitation of cashless arrangement by the representative of TPA.

b. Facilitation at the time of discharge by the representative of TPA.

c. Pick and drop service for all the claim documents, including Pre and Post Hospitalisation bills, by the representative of TPA.

In case of omission by the TPA to arrange to provide this service, our liability for such omission will be limited to Rs. 5,000 per Hospitalisation.

Conditions: The benefits under this clause shall be applicable only where the Insured Person provides advance notice to TPA as mentioned in the Schedule at least seventy-two hours prior to date of Hospitalisation.

24. DOES IT COVER ALL CASES OF HOSPITALISATION?

No. This Policy does NOT cover ALL cases of Hospitalisation.

The exclusions under the policies are:

i. PRE-EXISTING DISEASES (Code- Excl01)

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.

b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

ii. SPECIFIC WAITING PERIOD (Code- Excl02)

a. Expenses related to the treatment of the following listed conditions, surgeries / treatments shall be excluded until the expiry of 24 / 36 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c. If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

(i) 90 Days Waiting Period

1. Diabetes Mellitus
2. Hypertension
3. Cardiac Conditions

(ii) 24 Months waiting period

1. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
2. Benign ear, nose, throat disorders
3. Benign prostate hypertrophy
4. Cataract and age related eye ailments
5. Gastric/ Duodenal Ulcer
6. Gout and Rheumatism
7. Hernia of all types
8. Hydrocele
9. Non Infective Arthritis
10. Piles, Fissures and Fistula in anus
11. Pilonidal sinus, Sinusitis and related disorders
12. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
13. Renal Disorders
14. Skin Disorders
15. Stone in Gall Bladder and Bile duct, excluding malignancy
16. Stones in Urinary system
17. Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapsed uterus
18. Varicose Veins and Varicose Ulcers
19. Puberty and Menopause related Disorders
20. Behavioural and Neuro-Developmental Disorders:
    a. Disorders of adult personality
    b. Disorders of speech and language including stammering, dyslexia
21. Internal Congenital Diseases

    Note: Even after twenty-four months of Continuous Coverage, the above Illnesses will not be covered if they arise from a Pre-existing Condition, until 36 months of Continuous Coverage have elapsed since inception of the first Policy with the Company.

(iii) 36 Months waiting period

1. Joint Replacement due to Degenerative Condition
2. Age-related Osteoarthritis & Osteoporosis
3. Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders.
4. Age Related Macular Degeneration (ARMD)
5. Genetic diseases or disorders
6. External Congenital Diseases

iii. FIRST THIRTY DAYS WAITING PERIOD (Code- Excl03)

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

EXCLUSIONS

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of.

A. INVESTIGATION & EVALUATION (Code- Excl04)

a. Expenses related to any admission primarily for diagnostics and evaluation purposes.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment.

However, Treatment for any symptoms, Illness, complications arising due to physiological conditions for which aetiology is unknown is not excluded. It is covered with a Sub-Limit of upto 10% of Sum Insured per policy period.

B. REST CURE, REHABILITATION AND RESPITE CARE (Code- Excl05) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

However, Expenses related to any admission primarily for enteral feedings is not excluded, if the Oral intake is absent for a period of at-least 5 days. It will be covered for a Maximum period of 14 days in a Policy Period.

C. CHANGE-OF-GENDER TREATMENTS (Code- Excl07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

D. COSMETIC OR PLASTIC SURGERY (Code- Excl08)

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

E. HAZARDOUS OR ADVENTURE SPORTS (Code- Excl09)

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving except as provided under 3.1.14.

However, Treatment related to Injury or Illness associated with Hazardous activities related to particular line of employment or occupation (not for recreational purpose) is not excluded.

F. BREACH OF LAW (Code- Excl10)

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

G. EXCLUDED PROVIDERS (Code-Excl11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

H. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12).**

I. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code- Excl13).**

J. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **(Code- Excl14)**

K. REFRACTIVE ERROR (Code- Excl15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

L. UNPROVEN TREATMENTS (Code- Excl16)

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

M. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

N. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

O. Any expenses incurred on Domiciliary Hospitalization.

P. Treatment taken outside the geographical limits of India.

Q. Vaccination and/or inoculation.

R. Dental treatment or Surgery of any kind unless necessitated by accident and requiring Hospitalisation.

S. Bodily Injury or Illness due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted Injury, attempted suicide.

However, Failure to seek or follow medical advice or failure to follow treatment is not excluded. It is covered with a sub-limit of 10% of Sum Insured per policy period.

T. Treatment of any Injury or Illness sustained whilst or as a result of participating in any criminal act.

U. External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP (Continuous Positive Airway Pressure), Sleep Apnoea Syndrome, CPAD (Continuous Peritoneal Ambulatory Dialysis), Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump etc. Ambulatory devices i.e., walker, crutches, Belts, Collars, Caps, Splints, Slings, Stockings, elastocrepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer / Thermometer, alpha / water bed and similar related items etc., and also any medical equipment, which is subsequently used at home.

V. Stem cell implantation / Surgery for other than those treatments mentioned in Policy Clause 3.1.17.12.

W. Acupressure, acupuncture, magnetic therapies.

X. Any kind of Service charges, Surcharges, Luxury Tax and similar charges levied by the Hospital.

Y. Convalescence, General debility and Venereal disease.

Z. Cost of braces, equipment or external prosthetic devices, non-durable implants, eyeglasses, Cost of spectacles and contact lenses, hearing aids including cochlear implants, durable medical equipment.

AA. Circumcision unless necessary for treatment of an Illness not excluded hereunder or as may be necessitated due to an accident.

AB. Treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External

Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.

25. WHAT IS A PRE EXISTING DISEASE?

The term Pre-existing condition/disease is defined in the Policy. It means any condition, ailment, Injury or Illness

a. That is/are diagnosed by a physician within 36 months prior to the effective date of the Policy issued by Us and its reinstatement or

b. For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the Policy or its reinstatement.

26. WHAT IS CONTINUOUS COVERAGE?

When a person is continuously Insured under a New India Premier Mediclaim Policy he is entitled to the benefit of Continuous Coverage. For instance, if a person has Continuous Coverage of more than thirty-six months, the exclusions relating to treatment of any Pre- existing Condition / Disease will not apply. However, the benefit of Continuous Coverage getting carried over for other Policies will not be available for following Coverage:

1. OPD Treatments
2. Maternity and Child Care
3. Treatment for Infertility
4. HIV/AIDS
5. Obesity Treatments

27. CAN CONTINUOUS COVERAGE FROM OTHER POLICIES BE CARRIED OVER TO NEW INDIA PREMIER MEDICLAIM POLICY?

Continuous Coverage from the following New India Policies can be carried over to the extent of coverage under such previous policies:

1) New India Mediclaim Policy
2) Yuva Bharat Health policy
3) New India Floater Mediclaim Policy
4) New India Asha Kiran Policy.

You can also carry over the Continuous Coverage, to the extent of cover, from your existing Policy with any other Insurer to New India Premier Mediclaim, subject to IRDAI -Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations,2024 and guidelines of IRDAI on Portability of Health Insurance Policies, as amended from time to time.

In case of change in Sum Insured during such uninterrupted coverage, the lowest Sum Insured would be reckoned for determining Continuous Coverage.

For instance: A person was covered for four years under New India Mediclaim for a Sum Insured of Rs. Five lakhs, and carries over this Continuous Coverage to New India Premier Mediclaim in 2017. If there is a claim for a Pre-existing Condition in 2017 for an amount of Rs. Eight lakhs, the claim will be admitted only to the extent of Rs. five lakhs since this is the amount available under Continuous Coverage for more than three years.

28. IS HOSPITALISATION ALWAYS NECESSARY TO GET A CLAIM?

Yes. Unless the Insured Person is Hospitalised for a condition warranting Hospitalisation, no claim is payable under the Policy.

This shall not be applicable to the treatments taken under OPD cover available under clause 3.1.10.

29. HOW LONG DOES THE INSURED PERSON NEED TO BE HOSPITALISED FOR MEDICLAIM PURPOSES?

The Policy pays only where the Hospitalisation is for more than twenty-four hours. But for certain Day Care Treatments as specified in the Policy, period of stay at the Hospital could be less than twenty-four hours. The Day Care Treatments are according to the table given in

Point No. 28 below. This shall not be applicable to the treatments taken under Our OPD cover under clause 3.1.10.

30. WHAT ARE THE DAY CARE TREATMENTS COVERED UNDER THIS POLICY?

Following are the day-care treatments covered under this Policy (treatments done within 24 hours).

1	Stapedotomy	**2**	Excision And Destruction Of A Lingual Tonsil
3	Stapedectomy	**4**	Other Operations On The Tonsils And Adenoids
5	Revision Of A Stapedectomy	**6**	Incision On Bone, Septic And Aseptic
7	Other Operations On The Auditory Ossicles	**8**	Closed Reduction On Fracture, Luxation Or Epiphyseolysis With Osteosynthesis
9	Myringoplasty (Type -I Tympanoplasty)	**10**	Suture And Other Operations On Tendons And Tendon Sheath
11	Tympanoplasty (Closure Of An Eardrum Perforation/Reconstruction Of The Auditory Ossicles)	**12**	Reduction Of Dislocation Under Ga
13	Revision Of A Tympanoplasty	**14**	Arthroscopic Knee Aspiration
15	Other Microsurgical Operations On The Middle Ear	**16**	Incision Of The Breast
17	Myringotomy	**18**	Operations On The Nipple
19	Removal Of A Tympanic Drain	**20**	Incision And Excision Of Tissue In The Perianal Region
21	Incision Of The Mastoid Process And Middle Ear	**22**	Surgical Treatment Of Anal Fistulas
23	Mastoidectomy	**24**	Surgical Treatment Of Haemorrhoids
25	Reconstruction Of The Middle Ear	**26**	Division Of The Anal Sphincter (Sphincterotomy)
27	Other Excisions Of The Middle And Inner Ear	**28**	Other Operations On The Anus
29	Fenestration Of The Inner Ear	**30**	Ultrasound Guided Aspirations
31	Revision Of A Fenestration Of The Inner Ear	**32**	Sclerotherapy Etc

33	Incision (Opening) And Destruction (Elimination) Of The Inner Ear	**34**	Incision Of The Ovary
35	Other Operations On The Middle And Inner Ear	**36**	Insufflation Of The Fallopian Tubes
37	Excision And Destruction Of Diseased Tissue Of The Nose	**38**	Other Operations On The Fallopian Tube
39	Operations On The Turbinates (Nasal Concha)	**40**	Dilatation Of The Cervical Canal
41	Other Operations On The Nose	**42**	Conisation Of The Uterine Cervix
43	Nasal Sinus Aspiration	**44**	Other Operations On The Uterine Cervix
45	Incision Of Tear Glands	**46**	Incision Of The Uterus (Hysterotomy)
47	Other Operations On The Tear Ducts	**48**	Therapeutic Curettage
49	Incision Of Diseased Eyelids	**50**	Culdotomy
51	Excision And Destruction Of Diseased Tissue Of The Eyelid	**52**	Incision Of The Vagina
53	Operations On The Canthus And Epicanthus	**54**	Local Excision And Destruction Of Diseased Tissue Of The Vagina And The Pouch Of Douglas
55	Corrective Surgery For Entropion And Ectropion	**56**	Incision Of The Vulva
57	Corrective Surgery For Blepharoptosis	**58**	Operations On Bartholin'S Glands (Cyst)
59	Removal Of A Foreign Body From The Conjunctiva	**60**	Incision Of The Prostate
61	Removal Of A Foreign Body From The Cornea	**62**	Transurethral Excision And Destruction Of Prostate Tissue
63	Incision Of The Cornea	**64**	Transurethral And Percutaneous Destruction Of Prostate Tissue
65	Operations For Pterygium	**66**	Open Surgical Excision And Destruction Of Prostate Tissue
67	Other Operations On The Cornea	**68**	Radical Prostatovesiculectomy
69	Removal Of A Foreign Body From The Lens Of The Eye	**70**	Other Excision And Destruction Of Prostate Tissue
71	Removal Of A Foreign Body From The Posterior Chamber Of The Eye	**72**	Operations On The Seminal Vesicles
73	Removal Of A Foreign Body From The Orbit And Eyeball	**74**	Incision And Excision Of Periprostatic Tissue
75	Operation Of Cataract	**76**	Other Operations On The Prostate
77	Incision Of A Pilonidal Sinus	**78**	Incision Of The Scrotum And Tunica Vaginalis Testis
79	Other Incisions Of The Skin And Subcutaneous Tissues	**80**	Operation On A Testicular Hydrocele
81	Parenteral Chemotherapy	**82**	Excision And Destruction Of Diseased

			Scrotal Tissue
83	Local Excision Of Diseased Tissue Of The Skin And Subcutaneous Tissues	**84**	Plastic Reconstruction Of The Scrotum And Tunica Vaginalis Testis
85	Other Excisions Of The Skin And Subcutaneous Tissues	**86**	Other Operations On The Scrotum And Tunica Vaginalis Testis
87	Simple Restoration Of Surface Continuity Of The Skin And Subcutaneous Tissues	**88**	Incision Of The Testes
89	Free Skin Transplantation, Donor Site	**90**	Excision And Destruction Of Diseased Tissue Of The Testes
91	Free Skin Transplantation, Recipient Site	**92**	Unilateral Orchidectomy
93	Revision Of Skin Plasty	**94**	Bilateral Orchidectomy
95	Other Restoration And Reconstruction Of The Skin And Subcutaneous Tissues	**96**	Orchidopexy
97	Chemosurgery To The Skin	**98**	Abdominal Exploration In Cryptorchidism
99	Destruction Of Diseased Tissue In The Skin And Subcutaneous Tissues	**100**	Surgical Repositioning Of An Abdominal Testis
101	Incision, Excision And Destruction Of Diseased Tissue Of The Tongue	**102**	Reconstruction Of The Testis
103	Partial Glossectomy	**104**	Implantation, Exchange And Removal Of ATesticular Prosthesis
105	Glossectomy	**106**	Other Operations On The Testis
107	Reconstruction Of The Tongue	**108**	Surgical Treatment Of A Varicocele And A Hydrocele Of The Spermatic Cord
109	Other Operations On The Tongue	**110**	Excision In The Area Of The Epididymis
111	Incision And Lancing Of A Salivary Gland And A Salivary Duct	**112**	Epididymectomy
113	Excision Of Diseased Tissue Of A Salivary Gland And A Salivary Duct	**114**	Reconstruction Of The Spermatic Cord
115	Resection Of A Salivary Gland	**116**	Reconstruction Of The Ductus Deferens And Epididymis
117	Reconstruction Of A Salivary Gland And A Salivary Duct	**118**	Other Operations On The Spermatic Cord, Epididymis And Ductus Deferens
119	Other Operations On The Salivary Glands And Salivary Ducts	**120**	Operations On The Foreskin
121	External Incision And Drainage In The Region Of The Mouth, Jaw And Face	**122**	Local Excision And Destruction Of Diseased Tissue Of The Penis
123	Incision Of The Hard And Soft Palate	**124**	Amputation Of The Penis
125	Excision And Destruction Of Diseased Hard And Soft Palate	**126**	Plastic Reconstruction Of The Penis
127	Incision, Excision And Destruction In The Mouth	**128**	Other Operations On The Penis
129	Plastic Surgery To The Floor Of The	**130**	Cystoscopical Removal Of Stones

	Mouth		
131	Palatoplasty	**132**	Lithotripsy
133	Other Operations In The Mouth	**134**	Coronary Angiography
135	Transoral Incision And Drainage Of A Pharyngeal Abscess	**136**	Haemodialysis
137	Tonsillectomy Without Adenoidectomy	**138**	Radiotherapy For Cancer
139	Tonsillectomy With Adenoidectomy		

31. WHAT DO I NEED TO DO IF A COVERED MEMBER NEEDS TO BE HOSPITALISED?

Upon the happening of any event which may give rise to a claim under the Policy, You need to intimate the TPA named in the schedule with all the details such as name of the Hospital, details of treatment, patient name, Policy number etc.

In case of emergency Hospitalisation, this information needs to be given to the TPA, within 24 hours from the time of Hospitalisation.

This is an important condition which needs to be complied with.

32. IS TREATMENT FOR HAZARDOUS SPORTS PAYABLE?

Yes. We shall pay expenses incurred towards treatment of any Injury or Illness arising out of the following hazardous sports only:

Bobsledding; Bungee Jumping; Canopying; Hang Gliding; Heli-skiing; Horseback Riding; Jet, Snow, and Water Skiing; Kayaking; Martial Arts; Speed Motorcycling; Mountain Biking; Mountain Climbing (under 14,000 feet); Paragliding; Parasailing; Safari; Scuba Diving, Skydiving; Snowboarding; Snowmobiling; Spelunking; Surfing; Trekking; Whitewater Rafting; Wind Surfing; Zip Lining, Equestrian; Fencing; Archery, Hot Air Ballooning; Underwater Sea- walk; Snorkeling; Rugby.

Our liability under this clause shall not exceed 10% of Sum Insured.

Payment under this clause is admissible only if the expenses are incurred in Hospital as In- Patient / Day Care Treatment in India.

33. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED BEFORE HOSPITALISATION?

Yes. Medical Expenses incurred sixty days prior to the date of Hospitalisation will be paid provided:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by Us.

iii. Such Medical Expenses are incurred not earlier than sixty days before the Date of Hospitalisation.

34. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED AFTER HOSPITALISATION?

Yes. Medical Expenses incurred ninety days after the date of discharge will be paid provided:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by Us.

iii. Such Medical Expenses are incurred not later than ninety days after the date of discharge from the Hospital.

35. IS THERE A LIMIT TO WHAT THE COMPANY WILL PAY FOR HOSPITALISATION?

Yes. We will pay Hospitalisation expenses up to a limit, known as Sum Insured. In cases where the Insured Person was Hospitalised more than once, the total of all amounts paid

a) for all cases of Hospitalisation,

b) expenses paid for medical expenses prior to Hospitalisation, and

c) expenses paid for medical expenses after discharge from Hospital shall not exceed the Sum Insured.

The Sum Insured under the Policy is available for any or all the members covered for one or more claims during the tenure of the Policy.

36. WHAT SUM INSURED SHOULD I CHOOSE?

You are free to choose any Sum Insured from Rs. 15 lakhs, 25, lakhs, 50 lakhs and 100 lakhs. The premium payable is determined on the following criteria:

1. The premium for the eldest member of the family. (Premium from Primary Member Premium Table)
2. Premium for rest of the members to be covered in this Policy. (Premium from Additional Member Premium Table)
3. Sum Insured

You are free to choose any Sum Insured available as specified above. But it is in your own interest to choose the Sum Insured which could satisfy your present as well as future needs.

37. HOW LONG IS THE POLICY VALID?

The Policy is valid for a period of one year from the date of inception. The validity of the Policy will be mentioned in the Schedule attached to the Policy. The entire premium for the mentioned period will be payable at the commencement of the Policy period.

38. WHEN SHOULD I RENEW MY PRESENT POLICY?

In order to get all Continuity benefits under the Policy, you can renew the Policy within thirty days prior to the expiry of the present Policy. For instance, if Your Policy commences from 2nd October, 2011 date of expiry is usually on 1st October, 2012. You can renew Your Policy by paying the Renewal Premium from 1st September 2012 to 1st October 2012.

39. WHAT IS CONTINUITY BENEFIT?

There are certain treatments which are payable only after the Insured Person is continuously covered for a specified period. For example, Cataract is covered only after twenty-four months of Continuous Coverage. If an Insured took a Policy in October, 2016, does not renew it on time and takes a Policy only in December 2017, and renewed it on time in December 2018, any claim for Cataract would not become payable, because the Insured Person was not continuously covered for twenty-four months. If, he had renewed the Policy in time in October 2017 and then in October 2018, then he would have been continuously covered for twenty-four months and therefore his claim for Cataract in the Policy beginning from October 2018 would be payable. Therefore, you should always ensure that you pay your renewal Premium before Your Policy expires.

40. IS THERE ANY GRACE PERIOD FOR RENEWAL OF THE POLICY?

Yes. If Your Policy is renewed within thirty days after the expiry of the previous Policy, then the Continuity Benefits would not be affected. But even if You renew Your Policy within thirty days after expiry of previous Policy, any Illness contracted or Injury sustained or Hospitalisation

commencing during the break in insurance is not covered. Therefore, it is in Your own interest to see that you renew the Policy before it expires.

41. IS THERE AN AGE LIMIT UPTO WHICH THE POLICY WOULD BE RENEWED?

No. Your Policy can be renewed, as long as you pay the Renewal Premium before the date of expiry of the Policy. There is an age limit for taking a fresh Policy, but there is no age limit for renewal. However, if you do not renew Your Policy before the date of expiry or within thirty days of the date of expiry, the Policy may not be renewed, and only a fresh Policy could be issued, subject to Our underwriting rules. In such cases, it is possible that a fresh

Policy could not be issued by Us. It is therefore in your interest to ensure that Your Policy is renewed before expiry.

42. CAN THE INSURANCE COMPANY REFUSE TO RENEW THE POLICY?

We may refuse to renew the Policy only under instances such as fraud, misrepresentation or non-disclosure of material facts or non-cooperation by You or any one acting on Your behalf in obtaining insurance or subsequently in relation thereto. If we discontinue selling this Policy, it will not be possible to renew this Policy on the same terms and conditions. In such a case you shall, however, have the option for renewal under any similar Policy being issued by the Company as on that date, provided the benefits payable shall be subject to the terms contained in such other Policy.

In case of revision or modification or withdrawal of the Policy a notice will be provided to You 90 days before such revision or modification or withdrawal.

Renewal can also be refused if the Policy is not renewed before expiry of the Policy or within the Grace Period.

43. CAN I MAKE A CLAIM IMMEDIATELY AFTER TAKING A POLICY?

Claims for Illnesses cannot be made during the first thirty days of a fresh Insurance Policy. However, claims for Hospitalisation due to Accidents occurring even during the first thirty days are payable. There are certain treatments where the waiting period is twelve months and thirty-six months are applicable. (Refer Q. No. 22 point 1,2,3 and Q. No. 23 for details)

44. WHO WILL SETTLE THE CLAIM?

Health claims are generally processed by Third Party Administrator (TPA). TPA is a service provider to facilitate service to you for providing Cashless facility for all Hospitalisation that come under the scope of the Policy. The TPA also processes reimbursement claims within the scope of the Policy. Payment of reimbursement claims will be effected by Us by transfer to Your bank account.

45. WHAT IS CASHLESS HOSPITALISATION?

Cashless Hospitalisation is service provided by the TPA on Our behalf whereby You are not required to settle the Hospitalisation expenses at the time of discharge from Hospital. The settlement is done directly by the TPA on Our behalf. However, those expenses which are not admissible under the Policy would not be paid and You would have to pay such inadmissible expenses to the Hospital. Cashless facility is available only in Network Hospitals. Prior approval is required from the TPA before the patient is admitted into the Network Hospital. You may visit our website at http://newindia.co.in/listofHospitals.aspx. The list of Network Hospitals can also be obtained from the TPA or from their website. You will have full freedom to choose the Hospitals from the Network Hospitals and avail Cashless facility on production of proof of Insurance and Your identity, subject to the claim being admissible. The TPA might not agree to provide Cashless

facility at a Hospital which is not a Network Hospital. In such cases You may avail treatment at any Hospital of Your choice and seek reimbursement of the claim subject to the terms and conditions of the Policy. In cases where the admissibility of the claim could not be determined with the available documents, even if the treatment is at a Network Hospital, the TPA may refuse to provide Cashless facility. Such refusal may not necessarily mean denial of the claim. You may seek reimbursement of the expenses incurred by producing all relevant documents and the TPA may pay the claim, if it is admissible under the terms and conditions of the Policy.

46. CAN I CHANGE HOSPITALS DURING THE COURSE OF MY TREATMENT?

Yes, it is possible to shift to another Hospital for reasons of requirement of better medical treatment. However, this will be evaluated by the TPA on the merits of the case and as per Policy terms and conditions.

47. HOW TO GET REIMBURSEMENT FOR PRE AND POST HOSPITALISATION EXPENSES?

The Policy allows reimbursement of Medical Expenses incurred before and after admissible Hospitalisation up to a certain number of days. For reimbursement, send all bills in original with supporting documents along with a copy of the discharge summary and a copy of the authorization letter to his/her TPA. The bills must be sent to the TPA within 7 days from the date of completion of treatment. You must also provide the TPA with additional information and assistance as may be required by the TPA in dealing with the claim.

48. WILL THE ENTIRE AMOUNT OF THE CLAIMED EXPENSES BE PAID?

The entire amount of the claim is payable, if it is within the Sum Insured and is related with the Hospitalisation as per Policy conditions and is supported by proper documents, except the expenses which are excluded. The list of such excluded expenses is attached as Annexure II (LIST OF EXPENSES EXCLUDED ("NON-MEDICAL")) to the Policy.

49. CAN ANY CLAIM BE REJECTED OR REFUSED?

Yes. A claim, which is not covered under the Policy conditions, can be rejected. Claims may also be rejected in the event of misrepresentation, mis-description or nondisclosure of any material fact/particular. In case You are not satisfied by the reasons for rejection, you can represent to Us within 15 days of such denial. If You do not receive a response to Your representation or if You are not satisfied with the response, you may write to our Cell, the details of which are provided at our website at http://newindia.co.in/Content.aspx?pageid=73. You may also call our Call Centre at the Toll-free number 1800-209-1415, which is available 24x7.

You also have the right to represent Your case to the Insurance Ombudsman. The contact details of the office of the Insurance Ombudsman could be obtained from http://www.irda.gov.in/ADMINCMS/cms/NormalData_Layout.aspx?page=PageNo234&mid=7.2

50. WHAT IS PORTABILITY AND MIGRATION?

Migration: means, a facility provided to policyholders (including all members under family cover and group Health insurance policy), to transfer the credit gained for pre-existing conditions and specific waiting period, from one health insurance policy to another with the same insurer.

You will have the option to migrate the policy to other Health Insurance products/plans offered by the company by applying for migration of the policy at-least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If You are presently covered and has been continuously covered without any lapses under any Health Insurance product/plan offered by the Company, then you can transfer the credit gained to the extent of the sum insured, no claim bonus, specific

waiting period for pre-existing diseases, moratorium period etc. in the previous policy to the migrated policy

Portability means the facility provided to the health insurance policyholder (including all members under family cover), to transfer the credits gained for pre-existing diseases and specific waiting periods, from one insurer to another insurer.

You will have the option to port the policy to other Insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at-least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If policyholder is presently covered and has been continuously covered without any lapses under any Health Insurance policy with an Indian General or Health Insurer, then policyholder can transfer the credit gained to the extent of the sum insured, no claim bonus, specific waiting period for pre-existing diseases, moratorium period etc from the existing insurer to the acquiring insurer in the previous policy

51. CAN I CANCEL THE POLICY?

Yes. You may cancel this policy by giving 7 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period at pro rata basis:

The insurer shall refund-

a. Refunds proportionate premium for unexpired policy period, if the term of policy up to one year and there is no claim (s) made during the policy period.

b. Refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

52. WHAT IS FREE LOOK PERIOD?

The Free Look Period shall be applicable on new individual health insurance policies, except for those policies of less than a year, renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

A period of 30 days (from the date of receipt of the policy document) is available to the policyholder to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. This option is available in case of policies with a term of one year or more.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by

the insured person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

53. IS THERE ANY BENEFIT UNDER THE INCOME TAX ACT FOR THE PREMIUM PAID FOR THIS INSURANCE?

Yes. Payments made for Health Insurance in any mode other than cash are eligible for deduction from taxable income as per Section 80 D of the Income Tax Act, 1961. For details, please refer to the relevant Section of the Income Tax Act.

54. IS CONGENITAL DISEASES COVERED IN THE POLICY?

Yes. Congenital Internal Disease or Defects or Anomalies, except those related to Genetic disorders, shall be covered up to Sum Insured, after twenty-four months of Continuous Coverage, if it was unknown to You or to the Insured Person at the commencement of such Continuous Coverage. Exclusion for Congenital Internal Disease or Defects or Anomalies would not apply to a New Born Baby during the year of Birth and also subsequent Renewals, if Premium is paid for such New Born Baby and the Renewals are effected before or within thirty days of expiry of the Policy.

Congenital External Disease or Defects or Anomalies shall be covered after thirty-six months of Continuous Coverage, but such cover for Congenital External Disease or Defects or Anomalies shall be limited to 10% of the Sum Insured in preceding thirty-six months.

55. HOW MUCH WILL BE REIMBURSED IF THE PERSON HAS MORE THAN ONE POLICY?

If two or more policies are taken by Insured Person during a period from one or more Insurers to indemnify treatment costs, Insured Person shall have the right to require a settlement of his claim in terms of any of the policies.

1. In all such cases Company shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of this policy.
2. If the amount to be claimed exceeds the Sum Insured under a single policy after considering the deductibles or co-pay, Insured Person shall have the right to choose Insurers from whom he wants to claim the balance amount.
3. Insured Person shall only be indemnified the Hospitalisation costs in accordance with the terms and conditions of the policy.

   Note: The Insured Person must disclose such other insurance at the time of making a claim under this Policy.

   None of the provisions of this Clause shall apply for payments under Hospital Cash Benefit and Critical Care Benefit.

56. WHAT WILL HAPPEN TO THE POLICY WHEN THE CHILD / CHILDREN BECOME FINANCIALLY INDEPENDENT AFTER TAKING THE POLICY?

The Company may offer an option to migrate to similar Health Insurance Policy once the child / children become financially independent.

57. ENHANCEMENT OF SUM INSURED:

You may seek enhancement of Sum Insured in writing before payment of premium for renewal, which may be granted at Our discretion. Before granting such request for enhancement of Sum

Insured, we have the right to have You examined by a Medical Practitioner authorized by Us or the TPA.

Enhancement of Sum Insured will not be considered for:

1) Any Insured Person over 65 years of age.
2) Any Insured Person who had undergone more than one Hospitalisation in the preceding two years.
3) Any Insured Person suffering from one or more of the following Illnesses/Conditions:
   a) Any chronic Illness
   b) Any recurring Illness

c) Any Critical Illness

Note:

i. In respect of any enhancement of Sum Insured, exclusions 4.1, 4.2 and 4.3 would apply to the additional Sum Insured from such date.

ii. Migration from Plan A to Plan B will only be considered up to 60 years of age

iii. On migration from Plan A to Plan B the covers available under Plan B will trigger only after competition of respective waiting periods.

iv. On migration from Plan A to Plan B the enhanced limits available under Plan B will be applicable only on completion of the waiting periods mentioned therein.

New India Premier Mediclaim Policy – Premium Chart

New India Premier Mediclaim Policy (Excluding GST)

PRIMARY MEMBER				
	Plan A		Plan B	
SI/Age	15 L	25L	50L	100L
<20	13771	16939	30748	38767
21-25	17554	22118	38524	50073
26-30	17788	22436	39010	50769
31-35	19544	24794	42650	55937
36-40	24184	31024	52280	69590
41-45	28479	36268	61841	81553
46-50	37183	47639	79325	105785
51-55	51554	66219	108055	145168
56-60	70297	90394	145252	196109
61-65	94762	121353	194371	261665
66-70	125299	162301	257783	351423

SECONDARY MEMBER				
	Plan A		Plan B	
	15L	25L	50L	100L
<20	10240	12596	22865	28827
21-25	13053	16446	28646	37234
26-30	13228	16683	29007	37752
31-35	14532	18437	31714	41594
36-40	17983	23069	38875	51747
41-45	21177	26969	45984	60642
46-50	27649	35423	58985	78661
51-55	38335	49239	80350	107945
56-60	52272	67216	108008	145825
61-65	70464	90237	144532	194571
66-70	93171	120685	191685	261314

New India Premier Mediclaim Policy (Including GST)

PRIMARY MEMBER				
	Plan A		Plan B	
SI/Age	15 L	25L	50L	100L
<20	16249	19988	36284	45746
21-25	20713	26099	45459	59087
26-30	20990	26474	46033	59908
31-35	23062	29257	50327	66006
36-40	28536	36609	61690	82117
41-45	33605	42797	72972	96232
46-50	43877	56213	93605	124826
51-55	60833	78139	127505	171299
56-60	82950	106665	171397	231409
61-65	111818	143197	229358	308765
66-70	147852	191514	304184	414679

SECONDARY MEMBER				
	Plan A		Plan B	
	15L	25L	50L	100L
<20	12084	14863	26980	34015
21-25	15402	19406	33803	43936
26-30	15609	19686	34229	44548
31-35	17148	21756	37423	49081
36-40	21220	27222	45872	61062
41-45	24989	31823	54262	71557
46-50	32625	41800	69603	92820
51-55	45235	58102	94812	127376
56-60	61681	79314	127449	172073
61-65	83147	106480	170548	229594
66-70	109942	142409	226189	308350

An increase of 2% per year in premium is applicable for every year after the age of 70.